(a) A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes. The rate of potentially preventable hospital admissions for diabetes is a composite measure of uncontrolled diabetes, short term diabetes complications, long term diabetes complications and lower extremity amputation for diabetes.

(b) A composite of rates of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia.

(c) Rates of an all-cause hospital readmissions measure.

§ 414.1235 Cost measures.

Costs for groups of physicians subject to the value-based payment modifier are assessed based on the following 6 cost measures:

(a) Total per capita costs for all attributed beneficiaries; and

(b) Total per capita costs for all attributed beneficiaries with diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure.

(c) Total per capita costs include all fee-for-service payments made under Medicare Part A and Part B.

(1) Payments under Medicare Part A and Part B will be adjusted using CMS' payment standardization methodology to ensure fair comparisons across geographic areas.

(2) The CMS–HCC model (and adjustments for ESRD status) is used to adjust standardized payments for each cost measure; that is—

(i) Total per capita costs; and

(ii) Total per capita costs for beneficiaries with the following conditions: coronary artery disease, COPD, diabetes, and heart failure.

§ 414.1240 Attribution for quality of care and cost measures.

Beneficiaries are attributed to groups of physicians subject to the value-based payment modifier using a method generally consistent with the method of assignment of beneficiaries under § 425.402 of this chapter.

§ 414.1245 Scoring methods for the value-based payment modifier using the quality-tiering approach.

For each quality of care and cost measure, a standardized score is calculated for each group of physicians subject to the value-based payment modifier by dividing—

(a) The difference between their performance rate and the benchmark, by

(b) The measure's standard deviation.

§ 414.1250 Benchmarks for quality of care measures.

(a) The benchmark for quality of care measures reported through the PQRS using the claims, registries, EHR, or web interface is the national mean for that measure's performance rate (regardless of the reporting mechanism) during the year prior to the performance period. In calculating the national benchmark, individuals' and groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the individuals' or group of physician's performance rate.

(b) The benchmark for each quality of care measure reported through the PQRS using the administrative claims option is the national mean for that measure's performance rate during the year prior to the performance period.

§ 414.1255 Benchmarks for cost measures.

The benchmark for each cost measure is the national mean of the performance rates calculated among all groups of physicians for which beneficiaries are attributed to the group of physicians and are subject to the value-based payment modifier. In calculating the national benchmark, groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the group of physician's performance rate.

§ 414.1260 Composite scores.

(a)(1) The standardized score for each quality of care measure is classified into one of the following equally weighted domains to determine the quality composite:

(i) Patient safety.

(ii) Patient experience.

(iii) Care coordination.

(iv) Clinical care.

(v) Population/community health.

(vi) Efficiency.

(2) If a domain includes no measure or does not reach the minimum case size in § 414.1265, the remaining domains are equally weighted to form the quality of care composite.

(b)(1) The standardized score for each cost measure is grouped into two separate and equally weighted domains to determine the cost composite:

(i) Total per capita costs for all attributed beneficiaries (one measures); and

(ii) Total per capita costs for all attributed beneficiaries with specific conditions: Diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure (four measures).

(2) Measures within each domain are equally weighted.

§ 414.1265 Reliability of measures.

To calculate a composite score for a quality or cost measure based on claims, a group of physicians subject to the value-based payment modifier must have 20 or more cases for that measure.

(a) In a performance period, if a group of physicians has fewer than 20 cases for a measure, that measure is excluded from its domain and the remaining measures in the domain are given equal weight.

(b) In a performance period, if a reliable quality of care composite or cost composite cannot be calculated, payments shall not be adjusted under the value-based payment modifier.

§ 414.1270 Determination and calculation of Value-Based Payment Modifier adjustments.

(a) *Downward payment adjustments.* A downward payment adjustment will be applied to a group of physicians subject to the value-based payment modifier if:

(1) Such group does neither self-nominates for the PQRS GPRO and reports at least one measure nor elects the PQRS administrative claims option for CY 2013 as defined in § 414.90(h);

(i) Such adjustment will be −1.0 percent.

(ii) [Reserved]

(2) Such group elects that its value-based payment modifier be calculated using a quality-tiering approach, and is determined to have poor performance (low quality and high costs),

(i) Such adjustment will not exceed −1.0 percent as specified in § 414.1275.

(ii) [Reserved]

(b) *No payment adjustments.* There will be no value-based payment modifier adjustment applied to a group of physicians subject to the value-based payment modifier if such group either

(1) Self-nominates for the PQRS GPRO and reports at least one measure; or

(2) Elects the PQRS administrative claims option for CY 2013 as defined in § 414.90(h).

(c) *Upward payment adjustments.* If a group of physicians subject to the value-based payment modifier elects that the value-based payment modifier be calculated using a quality-tiering approach, upward payment adjustments are determined based on the projected aggregate amount of downward payment adjustments determined under paragraph (a) of this section and applied as specified in § 414.1275.

§ 414.1275 Value-based payment modifier quality-tiering scoring methodology.

(a) The value-based payment modifier amount for a group of physicians subject to the value-based payment modifier that elects the quality-tiering approach is based upon a comparison of the composite of quality of care measures and a composite of cost measures.

(b) Quality composite and cost composite are classified into high, average, and low categories based on whether the composites are statistically above, not different from, or below the mean composite scores.

(1) Quality composites that are one or more standard deviations above the mean are classified into the high category. Quality composites that are one or more standard deviations below the mean are classified into the low category.

(2) Cost composites that are one or more standard deviations below the mean are classified into the low category. Cost composites that are one or more standard deviations above the